VERMONT
Office of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

Agency of Human Services

~ PSORIASIS INJECTABLE MEDICATIONS ~

Prior Authorization Request Form

Effective June, 2004, Vermont Medicaid established coverage limits and criteria for prior authorization of injectable psoriasis medications. These limits and criteria are based on concerns about safety when used with other medications, and efficacy. In order for beneficiaries to receive Medicaid coverage for these drugs, it will be necessary for the prescriber to telephone or complete and fax this prior authorization request to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Use this form for Injectable Psoriasis medication prior authorization requests only.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Name:_____
Phone #:_____
Fax #:_____
Address: _____
Specialty: _____

Beneficiary:

Name:_____
Medicaid ID #:_____
Date of Birth:_____ Sex:_____
Diagnosis: _____
Contact Person at Office: _____

Will this medication be billed via the: ☐ pharmacy benefit or ☐ medical benefit (J-code or other code)?

Pharmacy (if known)**:**_____ Phone:_____ &/or FAX:_____

Please select one of the following 'preferred' drug therapies from the VT Medicaid Preferred Drug List:

☐ **Enbrel** _____ Strength & Frequency:_____ Length of therapy:_____

☐ **Humira** _____ Strength & Frequency:_____ Length of therapy:_____

☐ **Raptiva** _____ Strength & Frequency:_____ Length of therapy:_____

For any other injectable psoriasis treatment, please explain medical necessity for non-preferred product:

Drug:_____ Strength & Frequency:_____ Length of therapy:_____

Medical justification:_____

_____

_____

List previous therapies (topical, phototherapy, oral) tried and failed for this condition:

Therapy	Reason for discontinuation	Dates Utilized
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Prescriber comments:

Prescriber Signature:_____ **Date of this request:**_____

Last Updated 06/08